AMENDED IN ASSEMBLY APRIL 6, 2005

CALIFORNIA LEGISLATURE—2005–06 REGULAR SESSION

ASSEMBLY BILL No. 977

Introduced by Assembly Member Nava

February 18, 2005

An act to add Section 1375 to the Health and Safety Code, and to add Section 10191.5 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 977, as amended, Nava. Health care review process.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime. Existing law provides for the licensure and regulation of health insurers by the Department of Insurance.

This bill would require a health care service plan and a health insurer*, except as specified,* to apply, respectively, to the Director of the Department of Managed Health Care and the Insurance Commissioner for approval to charge a deductible, copayment, or other out-of-pocket cost or to impose a limitation on benefits or coverage. The bill would require the director and commissioner to obtain public comment before deciding on the application and would specify factors the director or commissioner must consider in deciding on the application. The bill would require the director and commissioner to develop a schedule and process to also review existing plan contracts and policies, as specified.

Because the bill would specify additional requirements for health care service plans, the violation of which would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1375 is added to the Health and Safety Code, to read:

1375. (a) A health care service plan shall apply to the director before charging an enrollee or subscriber a deductible, copayment, or other out-of-pocket cost or before imposing a limitation on benefits or coverage. The director may approve or deny the application or approve it with conditions consistent with this section. A plan shall submit an application for each product that it markets in the individual market, small group market, and other group markets.

(b) The director shall provide public notice and seek public comment on the application at least 60 days prior to deciding its disposition. The director shall conduct one or more public meetings to receive public testimony. The director may extend the 60-day period if additional information or factors are brought ~~to his or her attention. In no instance shall the review period exceed 365 days from the date of the public notice.~~ *to his or her attention.*

(c) (1) The information provided to the public for review pursuant to subdivision (b) shall include the proposed plan contract as well as the proposed disclosures, if any, required pursuant to Sections 1363 and 1363.06. For products not subject to those sections, the information provided to the public for review shall include a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions, together with the corresponding copayments and limitations, in the following sequence:

(A) Deductibles.
(B) Lifetime maximums.
(C) Professional services.
(D) Outpatient services.
(E) Hospitalization services.
(F) Emergency health coverage.
(G) Ambulance services.
(H) Prescription drug coverage.
(I) Durable medical equipment coverage.
(J) Mental health services.
(K) Chemical dependency services.
(L) Home health services.
(M) Other benefits or limitations.

(2) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) The director shall consider the following factors in determining whether to approve an application or to deny or approve it with conditions:

(1) The type and number of enrollees that are affected or who are potentially affected by it.

~~(2) The implication of limitations and exclusions for clinical efficacy.~~

~~(3) The availability of therapeutic equivalents or other approaches for medically appropriate care or treatment.~~

~~(4)~~

(2) The specific services to which the copayment, coinsurance, deductible, limitation, or exclusion will apply.

~~(5) The duration of the limitation or exclusion, if any.~~

~~(6)~~

(3) The rationale for the copayment, coinsurance, deductible, limitation, or exclusion.

~~(7)~~

(4) The projected effect of the copayment, coinsurance, deductible, limitation, or exclusion on the affordability and accessibility of coverage for the enrollee *and the purchaser, if the enrollee is not the purchaser of coverage*.

~~(8)~~

(5) The projected comparative clinical effect, including any potential risk of adverse health outcomes, based upon utilization data and review of peer-reviewed professional literature.

~~(9)~~

(6) Whether the copayment, coinsurance, or deductible contributes to the overall out-of-pocket maximum for the product.

~~(10)~~

(7) Information regarding similar copayments, coinsurance levels, deductibles, limitations, or exclusions previously approved by the department.

~~(11)~~

(8) Evidence-based clinical studies and professional literature *regarding the impact of copayments, deductibles, exclusions, or limitations on access to appropriate or necessary care and treatment*.

~~(12)~~

(9) Any other historical, statistical, or other information that the applicant plan considers pertinent to the request for approval of the copayment, coinsurance level, deductible, limitation, or exclusion.

(10) In considering limitations and exclusions, the director shall also consider the following factors:

(A) The implication of limitations and exclusions for clinical efficacy of care or treatment.

(B) The availability of therapeutic equivalents or other approaches for medically appropriate care or treatment.

(C) The duration, if any, of the limitation or exclusion.

(e) The director shall require a plan to provide information with its application as may be necessary for the department to comply with this section.

(f) The director shall develop a schedule and process for the review of existing benefit designs to assure that products covering 90 percent or more of the enrollees or subscribers are reviewed consistent with this section.

(g) This section shall not apply to any of the following:

(1) A health care service plan contract authorized under Article 5.6 (commencing with Section 1374.60).

(2) A health care service plan contract for an enrollee in the Medi-Cal program, the Healthy Families Program, the Access

for Infants and Mothers Program, the California Major Risk Medical Insurance Program, or Medicare or and employee or annuitant subject to the Public Employees' Medical and Hospital Care Act.

(3) A health care service plan contract provided to an individual eligible for continued coverage under the Health Insurance Portability and Accountability Act or a conversion plan.

SEC. 2. Section 10191.5 is added to the Insurance Code, to read:

10191.5. (a) An insurer, as described in subdivision (b) of Section 106, shall apply to the commissioner before charging an insured a deductible, copayment, or other out-of-pocket cost or before imposing a limitation on benefits or coverage. The commissioner may approve or deny the application or approve it with conditions consistent with this section. An insurer shall submit an application for each product that it markets in the individual market, small group market, and other group markets.

(b) The commissioner shall provide public notice and seek public comment on the application at least 60 days prior to deciding its disposition. The commissioner shall conduct one or more public meetings to receive public testimony. The commissioner may extend the 60-day period if additional information or factors are brought to his or her attention. ~~In no instance shall the review period exceed 365 days from the date of the public notice.~~

(c) (1) The information provided to the public for review pursuant to subdivision (b) shall include the proposed policy as well as the proposed disclosures, if any, required under existing law. For products not subject to disclosure under existing law, the information provided to the public shall include a uniform health policy benefits and coverage matrix containing the policy's major provisions in order to facilitate comparisons between insurer policies. The uniform matrix shall include the following category descriptions, together with the corresponding copayments and limitations, in the following sequence:

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.
(F) Emergency health coverage.
(G) Ambulance services.
(H) Prescription drug coverage.
(I) Durable medical equipment.
(J) Mental health services.
(K) Chemical dependency services.
(L) Home health services.
(M) Other benefits or limitations.

(2) Nothing in this section shall prevent an insurer from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) The commissioner shall consider the following factors in determining whether to approve an application or to deny or approve it with conditions:

(1) The type and number of insureds that are affected or who are potentially affected by it.

~~(2) The implication of limitations and exclusions for clinical efficacy.~~

~~(3) The availability of therapeutic equivalents or other approaches for medically appropriate care or treatment.~~

~~(4)~~

(2) The specific services to which the copayment, coinsurance, deductible, limitation, or exclusion will apply.

~~(5) The duration of the limitation or exclusion, if any.~~

~~(6)~~

(3) The rationale for the copayment, coinsurance, deductible, limitation, or exclusion.

~~(7)~~

(4) The projected effect of the copayment, coinsurance, deductible, limitation, or exclusion on the affordability and accessibility of coverage for the insured *and the purchaser, if the insured is not the purchaser of the coverage*.

~~(8)~~

(5) The projected comparative clinical effect, including any potential risk of adverse health outcomes, based upon utilization data and review of peer-reviewed professional literature.

~~(9)~~

(6) Whether the copayment, coinsurance, or deductible contributes to the overall out-of-pocket maximum for the product.

~~(10)~~

(7) Information regarding similar copayments, coinsurance levels, deductibles, limitations, or exclusions previously approved by the department.

~~(11)~~

(8) Evidence-based clinical studies and professional literature *regarding the impact of copayments, deductibles, exclusions, or limitations on access to appropriate or necessary care and treatment*.

~~(12)~~

(9) Any other historical, statistical, or other information that the applicant considers pertinent to the request for approval of the copayment, coinsurance level, deductible, limitation, or exclusion.

(10) In considering limitations and exclusions, the commissioner shall also consider the following factors:

(A) The implication of limitations and exclusions for clinical efficacy of care or treatment.

(B) The availability of therapeutic equivalents or other approaches for medically appropriate care or treatment.

(C) The duration, if any, of the limitation or exclusion.

(e) The commissioner shall require an insurer to provide information with its application as may be necessary for the department to comply with this section.

(f) The commissioner shall develop a schedule and process for the review of existing benefit designs to assure that products covering 90 percent or more of the insureds are reviewed consistent with this section.

(g) This section shall not apply to either of the following:

(1) A health insurance policy for an insured in the Medi-Cal program, the Healthy Families Program, the access for Infants and Mothers Program, the California Major Risk Medical Insurance Program, or Medicare or an employee or annuitant subject to the Public Employees' Medical and Hospital Care Act.

(2) A health insurance policy provided to an individual eligible for continued coverage under the Health Insurance Portability and Accountability Act or a conversion plan.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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